

		FOR OHF USE					

LL 1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0003079</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Hampton Nursing Care</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>P.O. Box 237</u> <u>Alhambra</u> <u>62001</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>Madison</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Dennis Gaudreault</u> (Title) <u>Administrator</u>																									
Telephone Number: <u>618-488-3565</u> Fax # <u>618-488-2517</u>		Paid Preparer (Signed) <u>See Accountant's Compilation Report</u> (Date) _____ (Print Name and Title) <u>Ronald C. Schneider, CPA</u> (Firm Name & Address) <u>Scheffel & Co PC P.O. Box 374 Highland, IL 62249</u> (Telephone) <u>618-654-9895</u> Fax # <u>618-654-9898</u>																									
IDPA ID Number: <u>37-0910603</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
Date of Initial License for Current Owners: <u>07/01/70</u>																											
Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																									
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																									
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																									
	<input checked="" type="checkbox"/> "Sub-S" Corp.																										
	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
In the event there are further questions about this report, please contact: Name: <u>Ronald C. Schneider</u> Telephone Number: <u>618-654-9895</u>																											

SEE ACCOUNTANT'S COMPILATION REPORT

Facility Name & ID Number Hampton Nursing Care# 0003079 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	84	Intermediate (ICF)	84	30,744	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,744	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	10,729	8,144		18,873	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,729	8,144		18,873	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 61.39%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/AF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 07/01/70

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Hampton Nursing Care

0003079

Report Period Beginning:

01/01/00

Ending:

12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	105,583	5,445	1,686	112,714		112,714		112,714		1
2	Food Purchase		112,027		112,027	349	112,376	(349)	112,027		2
3	Housekeeping	46,906	1,952		48,858		48,858		48,858		3
4	Laundry	15,213	467		15,680		15,680		15,680		4
5	Heat and Other Utilities			48,998	48,998		48,998		48,998		5
6	Maintenance	32,184	16,615		48,799		48,799		48,799		6
7	Other (specify):*										7
8	TOTAL General Services	199,886	136,506	50,684	387,076	349	387,425	(349)	387,076		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	673,474	37,554	17,796	728,824		728,824		728,824		10
10a	Therapy										10a
11	Activities	17,304	1,161		18,465		18,465		18,465		11
12	Social Services	28,542		1,743	30,285		30,285		30,285		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	719,320	38,715	19,539	777,574		777,574		777,574		16
	C. General Administration										
17	Administrative	81,102			81,102		81,102		81,102		17
18	Directors Fees										18
19	Professional Services			29,787	29,787		29,787	1,040	30,827		19
20	Dues, Fees, Subscriptions & Promotions			6,546	6,546	110	6,656	(3,365)	3,291		20
21	Clerical & General Office Expenses	29,868	5,542	6,864	42,274		42,274		42,274		21
22	Employee Benefits & Payroll Taxes			89,057	89,057	29,818	118,875		118,875		22
23	Inservice Training & Education										23
24	Travel and Seminar			250	250		250		250		24
25	Other Admin. Staff Transportation			7,403	7,403		7,403		7,403		25
26	Insurance-Prop.Liab.Malpractice			49,469	49,469	(29,818)	19,651		19,651		26
27	Other (specify):*			3,184	3,184	(459)	2,725	(695)	2,030		27
28	TOTAL General Administration	110,970	5,542	192,560	309,072	(349)	308,723	(3,020)	305,703		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,030,176	180,763	262,783	1,473,722		1,473,722	(3,369)	1,470,353		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number

Hampton Nursing Care

#0003079

Report Period Beginning:

01/01/00

Ending:

12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			25,776	25,776		25,776	25,135	50,911			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5	5		5	70,702	70,707			32
33	Real Estate Taxes			44,557	44,557		44,557		44,557			33
34	Rent-Facility & Grounds			57,467	57,467		57,467	(57,467)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			127,805	127,805		127,805	38,370	166,175			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			45,990	45,990		45,990		45,990			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			45,990	45,990		45,990		45,990			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,030,176	180,763	436,578	1,647,517		1,647,517	35,001	1,682,518			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Nursing Care

0003079

Report Period Beginning: 01/01/00

Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	3,373	30		9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(349)	2		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties	(695)	27		18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional	(2,145)	20		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising	(1,220)	20		28
29 Other-Attach Schedule				29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,036)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	36,037	19,30,32,3	34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 36,037		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ 35,001		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.			\$		38
39					39
40 Gift and Coffee Shops					40
41 Barber and Beauty Shops					41
42 Laboratory and Radiology					42
43 Prescription Drugs					43
44 Exceptional Care Program					44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1	\$	1
2		2
3		3
4		4
5		5
6		6
7		7
8		8
9		9
10		10
11		11
12		12
13		13
14		14
15		15
16		16
17		17
18		18
19		19
20		20
21		21
22		22
23		23
24		24
25		25
26		26
27		27
28		28
29		29
30		30
31		31
32		32
33		33
34		34
35		35
36		36
37		37
38		38
39		39
40		40
41		41
42		42
43		43
44		44
45		45
46		46
47		47
48		48
49		49
50		50
51		51
52		52
53		53
54		54
55		55
56		56
57		57
58		58
59		59
60		60
61		61
62		62
63		63
64		64
65		65
66		66
67		67
68		68
69		69
70		70
71		71
72		72
73		73
74		74
75		75
76		76
77		77
78		78
79		79
80		80
81		81
82		82
83		83
84		84
85		85
86		86
87		87
88		88
89		89
90 Total	0	90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hampton Nursing Care

0003079

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(349)	0	0	0	0	0	0	0	0	0	0	(349)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(349)	0	0	0	0	0	0	0	0	0	0	(349)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,365)	0	0	0	0	0	0	0	0	0	0	(3,365)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(695)	0	0	0	0	0	0	0	0	0	0	(695)	27
28	TOTAL General Administration	(4,060)	0	0	0	0	0	0	0	0	0	0	(4,060)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,409)	0	0	0	0	0	0	0	0	0	0	(4,409)	29

Summary B

12/31/00

12/31/00

[illegible]

Facility Name & ID Number Hampton Nursing Care

0003079

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCOTT HAMPTON LIVING TRUST	100.00	N/A				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V		ACCTG FEES & FIDUCIARY	\$	SCOTT HAMPTON LIVING TRUST	100.00%	\$ 1,040	\$ 1,040	1
2	V		DEPRECIATION		SCOTT HAMPTON LIVING TRUST	100.00%	21,762	21,762	2
3	V		INTEREST		SCOTT HAMPTON LIVING TRUST	100.00%	70,702	70,702	3
4	V		RENT - FACILITY & GROUNDS	57,467	SCOTT HAMPTON LIVING TRUST	100.00%		(57,467)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 57,467			\$ 93,504	\$ * 36,037	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Nursing Care # 0003079 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Scott Hampton	President	Business Manager	100.00	0	40	100.00	SALARY	\$ 40,083	17-1	1
2	James Richey 1/1-4/30	Administrator	Administrator	0.00	0	40	100.00	SALARY	12,886	17-1	2
3	Verna Germanceri 1/1-3/31	Director of Nursing	Director of Nursin	0.00	0	40	100.00	SALARY	7,568	10-1	3
4	Dennis Gaudreault 6/30-12/31	Administrator	Administrator	0.00	0	40	100.00	SALARY	23,054	17-1	4
5	Sharon Winklemeier 11/15-12/	Director of Nursing	Director of Nursin	0.00	0	40	100.00	SALARY	3,076	10-1	5
6	Jessica Fritz 5/1-6/29	Administrator	Administrator	0.00	0	40	100.00	SALARY	5,079	17-1	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 91,746		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Nursing Care# 0003079

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	BANK OF EDWARDSVILLE		X	50% OF REAL ESTATE AND	\$7,448.00	03/06/92	\$ 890,000	\$ 901,566	11/26/00	8.2500	\$ 70,702	1	
2				REFINANCING.								2	
3				BALANCE INCREASED TO								3	
4				PAY PAST DUE BILLS AND								4	
5				REAL ESTATE TAXES.								5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$7,448.00		\$ 890,000	\$ 901,566			\$ 70,702	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 890,000	\$ 901,566			\$ 70,702	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Hampton Nursing Care**# **0003079** Report Period Beginning: **01/01/00** Ending: **12/31/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	44,557	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	44,569	2
3. Under or (over) accrual (line 2 minus line 1).	\$	12	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	44,545	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	44,557	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	38,681	8
	1996	39,825	9
	1997	41,398	10
	1998	44,687	11
	1999	44,557	12

	FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 15,454

B. General Construction Type:
 Exterior
 Brick
 Frame
 Number of Stories
 1

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	48 BEDS	11,027	1970	\$ 7,550	1
2	36 BEDS	4,156	1979	16,041	2
3	TOTALS	15,183		\$ 23,591	3

SEE ACCOUNTANTS' COMPILATION REPORT

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Ice Machine Roof	1995		525	26	20	26		157
10	Concrete	1995		343	17	20	17		103
11	Paneling	1995		406	27	15	27		162
12	Paneling	1995		6,674	445	15	445		2,592
13	Ice Machine Roof	1995		676	34	20	34		203
14	Floor Tile	1995		1,731	115	15	115		682
15	Landscaping	1995		8,766	810	15	810		5,336
16	Sidewalk	1995		2,055	103	20	103		591
17	Door Panels	1995		651	26	25	26		152
18	Lattice	1995		252	17	15	17		95
19	Remodel Bathrooms	1995		14,690	577	15-30	577		3,068
20	Doors	1995		2,109	134	10-20	134		741
21	Smoking Room	1995		2,701	108	25	108		594
22	Storage Room	1995		203	8	25	8		45
23	Dir Of Nursing Office	1995		1,658	99	10-25	99		537
24	A/C Compressor	1995		717	72	10	72		395
25	Laundry Room	1995		280	11	25	11		60
26	Office A/C	1995		2,872	144	20	144		778
27	A/C	1995		8,811	441	20	441		2,379
28	Trees	1996		654	44	15	44		207
29	Landscaping	1996		10,091	1,009	10	1,009		4,692
30	Concrete Sidewalks	1996		2,783	139	20	139		661
31	Nurses Station	1997		2,520	84	30	84		322
32	Window	1997		1,738	58	30	58		217
33	Landscaping	1997		1,043	104	10	104		382
34									
35									
36	TOTAL (lines 4 thru 35)			\$ 74,949	\$ 4,652		\$ 4,652	\$ 0	\$ 25,151

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

- o Page 12A
- o Page 12B
- o Page 12C
- o Page 12D

Facility Name & ID Number Hampton Nursing Care

0003079

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	6		1971	1971	\$ 38,500	\$ 1,167	33	\$ 1,167		\$ 33,737	4
5	18		1973	1973	115,500	3,500	33	3,500		96,250	5
6	24		1976	1976	192,845	6,221	31	6,221		152,410	6
7	24		1979	1979	152,637	3,625	10-35	3,625		104,904	7
8	12		1983	1983	232,663	6,648	35	6,648		116,332	8
	Improvement Type**										
9	Sprinkler System			1979	8,312	332	25	332		7,175	9
10	Sidewalks and Driveways			1979	2,150		10			2,150	10
11	Remodeling			1979	7,522	269	28	269		5,866	11
12	Leasehold Improvements Scheduled				24,745		5-12			24,745	12
13	Roof			1984	11,687	467	25	467		7,791	13
14	Various Others			1984	2,737		5-10			2,737	14
15	Computer Wiring			1984	3,972		10			3,972	15
16	Remodeling			1984	3,066		10			3,066	16
17	Remodeling			1985	1,486		10			1,486	17
18	Remodeling			1986	7,832		10			7,832	18
19	Roof			1986	18,530	618	30	618		8,802	19
20	Remodeling			1986	6,311		10			6,311	20
21	Windows			1987	1,556	78	20	78		1,083	21
22	Trees			1986	375		10			375	22
23	Remodeling			1987	6,005		10			5,892	23
24	Remodeling			1987	1,968		10			1,968	24
25	Patio Fence			1988	880	59	15	59		738	25
26	Walkway and Sidewalk			1989	1,051	50	10-20	50		725	26
27	Kitchen Remodel			1990	1,372	69	20	69		751	27
28	Kitchen Remodel			1991	4,925	406	10-25	406		3,922	28
29	Landscaping			1992	2,057	137	15	137		1,143	29
30	Air Cond Compressor			1993	1,103	55	20	55		404	30
31	Fire Alarm System			1994	1,854	93	20	93		626	31
32	Dining Room Remodel			1994	5,033	252	20	252		1,610	32
33	Carpet			1994	2,699		5			2,699	33
34	Painting, Wallpaper, Paneling			1994	6,426	428	15	428		2,606	34
35	Rounding Amount										35
36	TOTAL (lines 4 thru 35)				\$ 867,799	\$ 24,474		\$ 24,474	\$	\$ 610,108	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOF		1997		5,309	177	30	177		605	9
10	WALL MOUNT		1997		700	23	30	23		79	10
11	FURNACE		1998		2,483	124	20	124		362	11
12	WIRING		1998		996	50	20	50		137	12
13	WINDOW REPLACEMENT		1998		395	13	30	13		27	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 9,883	\$ 387		\$ 387	\$ 0	\$ 1,210	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

- o Page 12A
- o Page 12B
- o Page 12C
- o Page 12D

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 196,403	\$ 17,845	\$ 21,218	\$ 3,373	5-20	\$ 102,652	37
38	Current Year Purchases	3,603	180	180		5-20	180	38
39	Fully Depreciated Assets	145,561					145,561	39
40								40
41	TOTALS	\$ 345,567	\$ 18,025	\$ 21,398	\$ 3,373		\$ 248,393	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 1,321,789	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 47,538	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 50,911	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 3,373	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 884,862	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	OFFICE 1971	\$ 19,400	\$	\$ 19,400	52
53					53
54					54
55					55
56					56
57	TOTALS	\$ 19,400	\$	\$ 19,400	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	PATIENT CARE	96 TAURUS WAGON	\$ 420.00	\$ 3,485	17
18					18
19					19
20					20
21	TOTAL		\$ 420.00	\$ 3,485	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2001 \$ _____

13. _____/2002 \$ _____

14. _____/2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
	Licensed Speech and Language										
2	Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)										
10			hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$		1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	122,359		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,386		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>L/R Trust</u>	124,488		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 259,233	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	202,502		15
16	Equipment, at Historical Cost	345,567		16
17	Accumulated Depreciation (book methods)	(366,039)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 182,030	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 441,263	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 101,495	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	12,726		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,286		31
32	Accrued Real Estate Taxes(Sch.IX-B)	44,545		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	143		35
	Other Current Liabilities(specify):			
36	<u>Bank Overdraft</u>	4,464		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 175,659	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	269,911		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 269,911	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 445,570	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (4,307)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 441,263	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 170,275	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 170,275	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(155,128)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(19,454)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (174,582)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (4,307)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Hampton Nursing Care

0003079

Report Period Beginning: 01/01/00

Ending:

12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,500,697	1
2	Discounts and Allowances for all Levels	(8,695)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,492,002	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	387	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 387	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,492,389	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	387,425	31
32	Health Care	777,574	32
33	General Administration	308,723	33
B. Capital Expense			
34	Ownership	127,805	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	45,990	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,647,517	40
41	Income before Income Taxes (line 30 minus line 40)**	(155,128)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (155,128)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Hampton Nursing Care**# **0003079**Report Period Beginning: **01/01/00**

Ending:

12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	500	596	\$ 10,644	\$ 17.86	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	24,128	24,428	344,672	14.11	4
5	Nurse Aides & Orderlies	35,461	35,909	318,158	8.86	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,241	2,265	17,304	7.64	9
10	Activity Assistants					10
11	Social Service Workers	3,617	3,641	28,542	7.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,943	16,319	105,583	6.47	15
16	Dishwashers					16
17	Maintenance Workers	3,183	3,193	32,184	10.08	17
18	Housekeepers	8,077	8,172	46,906	5.74	18
19	Laundry	2,652	2,817	15,213	5.40	19
20	Administrator	2,000	2,064	41,019	19.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,000	2,080	40,083	19.27	23
24	Clerical	3,213	3,308	29,868	9.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	103,015	104,792	\$ 1,030,176 *	\$ 9.83	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	42	\$ 1,686	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	186	2,413	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	42	1,743	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	270	\$ 5,842		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	769	15,336	10-3	52
53	TOTAL (lines 50 - 52)	769	\$ 15,336		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Hampton Nursing Care**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
James Richey 1/1-4/30/00	Nursing Home	0	\$ 12,886	Workers' Compensation Insurance	\$ 29,818	IDPH License Fee	\$ 400	
	Administrator			Unemployment Compensation Insurance	10,119	Advertising: Employee Recruitment	925	
Dennis Gaudreault 6/30-12/31	Nursing Home	0	23,054	FICA Taxes	78,334	Health Care Worker Background Check		
	Administrator			Employee Health Insurance		(Indicate # of checks performed 2)	110	
Scott Hampton	Business Mgr	100	40,083	Employee Meals		Newspapers	41	
Jessica Fritz 5/1-6/29	Nursing Home	0	5,079	Illinois Municipal Retirement Fund (IMRF)*		Professional Publications	55	
	Administrator			Employee Life Insurance	604	IHCA Dues	352	
TOTAL (agree to Schedule V, line 17, col. 1)						INHAA Dues	225	
(List each licensed administrator separately.)			\$ 81,102			Advertising	4,473	
B. Administrative - Other						Other License	75	
Description			Amount			Less: Public Relations Expense (
			\$			Non-allowable advertising	(2,145)	
						Yellow page advertising	(1,220)	
						TOTAL (agree to Sch. V, line 20, col. 8) \$ 3,291		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8) \$ 118,875				
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount			\$	Out-of-State Travel	\$
Scheffel & Co PC	Accountant		\$ 28,985					
Architectural Services	Architect		650					
Pell, Beatty, & Motil Law	Lawyer		152				In-State Travel	
							Seminar Expense	250
							Entertainment Expense (
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 29,787				TOTAL	\$ 250

* Attach copy of IMRF notifications

****See instructions.**

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hampton Nursing Care

STATE OF ILLINOIS

0003079

Report Period Beginning:

01/01/00

Ending:

Page 23

12/31/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL HEALTH CARE ASSOC \$352
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,714 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 45,990
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes tm card If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ No employee meals
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 80%
- d. Have vehicle usage logs been maintained? YES
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A NO COMMUTING OR PERSONAL USE ALLOWED
- g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.